FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041822

Facility Name: Heartland Health Care Center-Macomb

Address: 8 Doctor Lane (Number) Macomb (City) 61455 (Zip Code)

County: McDonough

Telephone Number: (309) 833-5555 **Fax #** (309) 833-3749

IDPA ID Number: 34-1565996

Date of Initial License for Current Owners: 1966

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[X] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

In the event there are further questions about this report, please contact:
Name Craig Dekany, CPA Telephone Number: (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President of Reimbursement

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,228	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,228	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		555	4,645	5,200	8
9	SNF/PED					9
10	ICF	2,441	12,197	329	14,967	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,441	12,752	4,974	20,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 95.00%

D. How many bed-hold days during this year were paid by Public Aid? 37 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04 / 01 / 89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04 / 01 / 89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 4577

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	117,903	9,198	4,868	131,969	775	132,744	0	132,744			1
2	Food Purchase		105,464		105,464		105,464	(23,648)	81,816			2
3	Housekeeping	34,643	6,339	182	41,164		41,164	0	41,164			3
4	Laundry	29,458	6,707	210	36,375		36,375	0	36,375			4
5	Heat and Other Utilities			66,223	66,223	3,555	69,778	0	69,778			5
6	Maintenance	26,198	4,631	21,279	52,108		52,108	0	52,108			6
7	Other (specify): Med Waste			2,963	2,963		2,963	0	2,963			7
8	TOTAL General Services	208,202	132,339	95,725	436,266	4,330	440,596	(23,648)	416,948			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200	0	4,200			9
10	Nursing and Medical Records	653,631	55,783	11,854	721,268	14,050	735,318	0	735,318			10
10a	Therapy	99,587	5,729	34,540	139,856		139,856	0	139,856			10a
11	Activities	30,992	2,912	1,147	35,051		35,051	0	35,051			11
12	Social Services	56,054	210	1,046	57,310		57,310	0	57,310			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	840,264	64,634	52,787	957,685	14,050	971,735		971,735			16
	C. General Administration											
17	Administrative	51,018		155,361	206,379	(30,182)	176,197	0	176,197			17
18	Directors Fees							0				18
19	Professional Services			2,302	2,302	(2,222)	80	(80)				19
20	Dues, Fees, Subscriptions & Promotions			35,670	35,670		35,670	(23,893)	11,777			20
21	Clerical & General Office Expense	60,218	24,060	24,129	108,407	2,222	110,629	(7,654)	102,975			21
22	Employee Benefits & Payroll Taxes			291,484	291,484	(7,436)	284,048	0	284,048			22
23	Inservice Training & Education			1,152	1,152		1,152	0	1,152			23
24	Travel and Seminar			17,019	17,019		17,019	0	17,019			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			21,115	21,115		21,115	0	21,115			26
27	Other (specify):*							0				27
28	TOTAL General Administration	111,236	24,060	548,232	683,528	(37,618)	645,910	(31,627)	614,283			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,159,702	221,033	696,744	2,077,479	(19,238)	2,058,241	(55,275)	2,002,966			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			160,213	160,213	19,238	179,451	0	179,451			30
31	Amortization of Pre-Op. & Org.			6,914	6,914		6,914	0	6,914			31
32	Interest			4,087	4,087		4,087	0	4,087			32
33	Real Estate Taxes			29,472	29,472		29,472	761	30,233			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			8,046	8,046		8,046	0	8,046			35
36	Other (specify):*							0				36
37	TOTAL Ownership			208,732	208,732	19,238	227,970	761	228,731			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		167,139	24,065	191,204		191,204	0	191,204			39
40	Barber and Beauty Shops	104	35	4,908	5,047		5,047	0	5,047			40
41	Coffee and Gift Shops	13,921			13,921		13,921	0	13,921			41
42	Provider Participation Fee			31,842	31,842		31,842	0	31,842			42
43	Other (specify):* IV Ther. Drugs		504		504		504	0	504			43
44	TOTAL Special Cost Centers	14,025	167,678	60,815	242,518		242,518		242,518			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,173,727	388,711	966,291	2,528,729	0	2,528,729	(54,514)	2,474,215			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(23,648)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,770)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,723)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(18)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(891)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(80)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	4,187	21		24
25	Fund Raising, Advertising and Promotional	(23,893)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	761	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,439)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,514)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (54,514)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name Heartland Health Care Center-Macomb

IDPH 0001822

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(23,448)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	(23,668)	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(2,778)	21	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	(23,668)
9	**Non-Straightline Depreciation**	0	0	**Line 9**	0
10	**Interest and Other Investment Income**	0	0	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(2,723)	21	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	(18)	21	**Line 15**	0
17	**Non-Care Related Fees**	0	0	**Line 16**	0
18	**Fines and Penalties**	0	0	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	(891)	21	**Line 19**	(891)
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	(23,891)
22	**Special Legal Fees & Legal Retainers**	(80)	19	**Line 21**	(17,893)
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	4,187	21	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(23,893)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement**	761	33	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(31,427)
30	**Donated Goods**	0	0	**Line 29**	(93,230)
31	**Amortization Expense**	0	0	**Line 30**	0
32	Other Misc Income	(5,439)	21	**Line 31**	0
				Line 32	0
				Line 33	761
				Line 34	0
				Line 35	0
				Line 36	0
				Line 37	761
				Line 38	0
				Line 39	0
				Line 40	0
				Line 41	0
				Line 42	0
				Line 43	0
				Line 44	0
				Line 45	(94,719)

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(23,648)	0	0	0	0	0	0	0	0	0	0	(23,648)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(23,648)	0	0	0	0	0	0	0	0	0	0	(23,648)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(80)	0	0	0	0	0	0	0	0	0	0	(80)	19
20	Fees, Subscriptions & Promotions	(23,893)	0	0	0	0	0	0	0	0	0	0	(23,893)	20
21	Clerical & General Office Expenses	(7,654)	0	0	0	0	0	0	0	0	0	0	(7,654)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,627)	0	0	0	0	0	0	0	0	0	0	(31,627)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(55,275)	0	0	0	0	0	0	0	0	0	0	(55,275)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	761	0	0	0	0	0	0	0	0	0	0	761	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	761	0	0	0	0	0	0	0	0	0	0	761	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(54,514)	0	0	0	0	0	0	0	0	0	0	(54,514)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe Heartland Health Care Center-Macomb # 0041822 Report Period Beginning 01/01/00 Ending: 12/31/00

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America	Toledo, OH			
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Page 1 Home Office Allocation	$ 155,361	HCR Manor Care, Inc	100.00%	$ 155,361	$	1
2	V	9						2
3	V							3
4	V							4
5	V							5
6	V	10a Therapy Management	12,000	Heartland Management Services	100.00%	12,000		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 167,361			$ 167,361	$ *	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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the name(s)
PORTS.

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT C... Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: HCR ManorCare, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (877) 329-7731

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary- Direct	Accumulated Cost	#########	357 Nurs. Fac	$	$	2,388,195	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	#########	357 Nurs. Fac.	671,002	407,536	2,388,195	775	2
3	5	Utilities - Direct	Accumulated Cost	#########	357 Nurs. Fac.	262,823		2,388,195	346	3
4	5	Utilities - Pooled	Accumulated Cost	#########	357 Nurs. Fac.	2,777,349		2,388,195	3,209	4
5	10	Nursing - Direct	Accumulated Cost	#########	357 Nurs. Fac.	6,096,791	4,282,378	2,388,195	8,016	5
6	10	Nursing - Pooled	Accumulated Cost	#########	357 Nurs. Fac.	5,221,432	3,383,186	2,388,195	6,034	6
7	17	General & Admin. - Direct	Accumulated Cost	#########	357 Nurs. Fac.	23,025,730	19,694,773	2,388,195	30,276	7
8	17	General & Admin. - Pooled	Accumulated Cost	#########	357 Nurs. Fac.	82,128,599	31,955,235	2,388,195	94,903	8
9	22	Employee Benefits - Direct	Accumulated Cost	#########	357 Nurs. Fac.	2,724,065		2,388,195	3,582	9
10	22	Employee Benefits - Pooled	Accumulated Cost	#########	357 Nurs. Fac.	(9,534,453)		2,388,195	(11,018)	10
11	30	Depreciation - Direct	Accumulated Cost	#########	357 Nurs. Fac.	74,480		2,388,195	98	11
12	30	Depreciation - Pooled	Accumulated Cost	#########	357 Nurs. Fac.	16,563,680		2,388,195	19,140	12
13										13
14		Interest				14,161,817				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 144,173,315	$ 59,723,108		$ 155,361	25

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Purchase Facility		10/91	$ 53,357	$ 53,357			$ 4,087	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 53,357	$ 53,357			$ 4,087	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 53,357	$ 53,357			$ 4,087	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	28,711	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	29,472	2
3. Under or (over) accrual (line 2 minus line 1).	$	761	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	29,472	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	30,233	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	27,144	8
1996	27,310	9
1997	29,655	10
1998	28,711	11
1999	29,472	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,318 B. General Construction Type: Exterior Masonry Frame Steel, Fire resistant Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1983	$ 57,104	1
2					2
3	TOTALS			$ 57,104	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	59		1983	1983	$ 824,586	$ 34,517	24	$ 34,517	$	$ 617,669	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	CURRENT YEAR DEPRECIATION					79,459		79,459		284,338	9
10	Land Improvements			1983	19,035						10
11	Land Improvements			1984	300						11
12	Building Improvements			1984	15,076						12
13	Building Improvements			1985	20,813						13
14	Building Improvements			1986	42,783						14
15	Land Improvements			1986	3,741						15
16	Building Improvements			1987	70,097						16
17	Building Improvements			1988	2,068						17
18	Land Improvements			1989	1,614						18
19	Building Improvements			1989	25,315						19
20	Land Improvements			1990	950						20
21	Building Improvements			1990	11,382						21
22	Building Improvements			1991	5,547						22
23	Building Improvements			1992	10,800						23
24	Land Improvements			1993	23,517						24
25	Building Improvements			1993	13,585						25
26	Building Improvements			1994	51,433						26
27	Land Improvements			1995	4,302						27
28	Building Improvements			1995	121,882						28
29	Land Improvements: Concrete and Paving			1996	30,357						29
30	Building Improvements: Smoke damper, wallcovering, tile floor,			1996	23,783						30
31	plumbing, cabinets, electrical wiring, paint, carpet, countertop,										31
32	HVAC and Air conditioning										32
33	Land Improvements			1996	2,652						33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 113,976		$ 113,976	$	$ 902,007	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Building Improvements: Painting and Wallcovering			1997	56,948						9
10	Building Improvements: VWC from Inventory			1997	2,425						10
11	Building Improvements: Carpet			1997	737						11
12	Building Improvements: Angle brackets for handrail, handrail,			1997	15,113						12
13	Cove base, wall protection										13
14	Building Improvements: Nurses stations remodeling, electrical w			1997	20,821						14
15	outlets & TV Rec										15
16	Building Improvements: Renovate Shower Room & Central Bath			1997	3,414						16
17	Building Improvements: Heating, Ventilation, Air Conditioning			1997	19,766						17
18	Building Improvements: Roof			1997	3,444						18
19	Building Improvements: Plumbing in Kitchen			1997	1,102						19
20	Building Improvements: Bookkeeping & Medical Records Office			1997	8,359						20
21	Renovations, Cabinets, drywall										21
22	Building Improvements: Addl't generator, perimeter alarm syste			1997	6,092						22
23	Land Improvements			1997	5,875						23
24	Land Improvements			1998	975						24
25	Building Improvements			1998	414						25
26	Bldg./Land Improvments			1998	5,285						26
27	Building Improvments			1998	620						27
28	Building Improvements			1998	704						28
29	Building Improvements			1998	25,173						29
30	Building Improvements			1998	8,245						30
31	Building Improvements: A/C heat roof, generator, fire alarm sys			1998	18,041						31
32	Building Improvements: Generator			1998	25,364						32
33	Building Improvements: HVAC			1998	284,108						33
34	Building Improvements: Fire alarm system			1998	21,706						34
35	Building Improvements: Ceiling tile nurses station			1998	1,446						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Smoking shelter			1999	4,950						9
10	Painting & Wallcovering			1999	3,457						10
11	Ductwork			1999	467						11
12	Re-key facility			1999	779						12
13	Overhead from const			1999	4,880						13
14	Overhead from const			1999	27,042						14
15	Painting			1999	1,245						15
16	Exit Fixtures			1999	2,074						16
17	Armstrong flooring			1999	443						17
18	Sprinkler upgrade			1999	14,500						18
19	Locking door hardware			1999	2,516						19
20	Sprinkler upgrade			1999	14,500						20
21	Door Locks			1999	1,434						21
22	Plumbing in restrooms			1999	1,330						22
23	Sprinkler upgrade			1999	26,084						23
24	Exit light			1999	2,074						24
25	Flow switch for sprinl			1999	342						25
26	Quarry tile			1999	9,916						26
27	Sprinkler upgrade			1999	5,798						27
28	Smoke doors			1999	1,184						28
29	HVAC			1999	1,557						29
30	Building improvements			1999	2,445						30
31	Doors & door openers			1999	3,500						31
32	Doors & frames			1999	11,283						32
33	Compressor for A/C			1999	3,705						33
34	Secure care system			1999	15,373						34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Doors			1999	2,750						9
10	Door			1999	200						10
11	Exterior door			1999	10,170						11
12	Retainage-fire alarm system			1999	2,146						12
13	Sidewalks			1999	9,020						13
14	Door Alarm			1999	1,475						14
15	Paving			1999	4,950						15
16	WALLCOVERING			2000	61						16
17	UPGRADE FIRE ALARM SYST			2000	1,121						17
18	CABINETS FOR BUSINESS OFFICE			2000	2,821						18
19	ELECTRICAL FOR BUS OFFICE			2000	375						19
20	ALARM SYSTEM REPAIRS			2000	808						20
21	ADDT'L CONST COST (CIP)			2000	10,258						21
22	HVAC			2000	18,151						22
23	HVAC CONSULTANT			2000	1,080						23
24	CARPET			2000	820						24
25	ADDT'L COST COUNTER TOPS			2000	313						25
26	CABINETS			2000	2,391						26
27	CARPET			2000	1,931						27
28	THERMO STAT			2000	1,594						28
29	FRT ON CARPET			2000	72						29
30	SOIL UTILITY RENOVATION			2000	3,240						30
31	SOIL UTILITY RENOVATION			2000	360						31
32	CABINETS/COUNTERTOPS			2000	266						32
33	KITCHEN HVAC			2000	2,017						33
34	SOIL UTILITY RENOVATION			2000	2,640						34
35	FULLY DEPRECIATED			2000	(79,120)						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 616,383	$ 46,237	$ 46,237	$		$ 556,966	37
38	Current Year Purchases	59,407						38
39	Fully Depreciated Assets							39
40	H/O Allocation		19,238	19,238				40
41	TOTALS	$ 675,790	$ 65,475	$ 65,475	$		$ 556,966	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Transport Residents	1986 Chevy Van	1986	$ 20,573	$	$	$		$ 20,573	42
43		Chair Lift for Van	1990	1,260					1,260	43
44		Running Board for Van	1995	877					877	44
45										45
46	TOTALS			$ 22,710	$	$	$		$ 22,710	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 179,451	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 179,451	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,481,683	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipm $ 8,046 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	778 hrs	$ 19,688	475	$ 11,874	$ 388	1,253	$ 31,950	1
2	Licensed Speech and Language Development Therapist	10a	973 hrs	27,723	72	1,803	61	1,045	29,587	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1,696 hrs	52,176	835	20,863	2,784	2,531	75,823	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts			3,465	167,058		170,523	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S -IV Ther., Lab,F	10a,39				20,859	2,577		23,436	13
14	TOTAL			$ 99,587	1,382	$ 58,864	$ 172,868	4,829	$ 331,319	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (7,695)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,336)	262,750		3
4	Supply Inventory (priced at)	16,503		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 271,558	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	168,366		13
14	Buildings, at Historical Cost	1,915,320		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	698,500		16
17	Accumulated Depreciation (book methods)	(1,481,683)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,300,503	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,572,061	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 24,812	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,077		30
31	Accrued Taxes Payable (excluding real estate taxes)	343		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,472		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	19,833		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 144,537	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	53,357		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 53,357	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 197,894	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,374,167	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,572,061	$	48

***(See instructions.)**

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Facility Name & ID Number Heartland Health Care Center-Macomb # 0041822 Report Period Beginning 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,304,910	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,304,910	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	338,515	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 338,515	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(269,258)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (269,258)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,374,167	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,242,140	1
2	Discounts and Allowances for all Levels	58,869	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,301,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	323,113	6
7	Oxygen	226	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 323,339	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,647	12
13	Barber and Beauty Care	5,584	13
14	Non-Patient Meals	23,648	14
15	Telephone, Television and Radio	4	15
16	Rental of Facility Space		16
17	Sale of Drugs	177,220	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,492	19
20	Radiology and X-Ray	1,307	20
21	Other Medical Services	843	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 242,745	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 151	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 2,867,244	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 436,266	31
32	Health Care	957,685	32
33	General Administration	683,528	33
	B. Capital Expense		
34	Ownership	208,732	34
	C. Ancillary Expense		
35	Special Cost Centers	242,518	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,528,729	40
41	**Income before Income Taxes (line 30 minus line 40)****	338,515	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 338,515	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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